3 Home Health Service Guidelines Contents

3.1 Introduction

3.1.1 General Policy

This section encompasses all Medicaid covered services provided by home health facilities. It addresses the following:

- Prior authorization
- Claims payment
- Home health revenue codes, type of bill, occurrence and status codes
- Electronic and paper claims billing

3.1.2 Client Eligibility

To be eligible for home health services, a client must have a physician's order as part of a plan of care. Home health services must be medically necessary and may include nursing services, supplies, home health aide services, durable medical equipment rentals, drugs, and physical or occupational therapy.

If a person is eligible for both Medicare and Medicaid, Medicaid's payment for services will not exceed the amount allowed by Medicaid minus Medicare's payment for those services.

Note: Home Health services are not covered under the CHIP-B program.

Refer to the **CHIP-B Appendix, section B.1.5** for service limitations for former CHIP-B participants.

3.1.3 Advanced Directives

Home health service providers must explain to each client his/her right to make decisions regarding his/her medical care. This includes the right to accept or refuse treatment. Home health care providers must inform the client of his/her right to formulate advance directives, such as a "living will" or durable power of attorney, before the client is under the provider's care.

3.1.4 Prior Authorization

Home health service providers do not need to request prior authorization for their services.

3.1.5 Payment

3.1.5.1 Customary Fees

Medicaid reimburses home health services on a per visit basis. Usual and customary fees are paid up to the Medicaid maximum allowance. All home health services must be billed by the home health provider on the UB92 claim form using the appropriate revenue and type of bill codes (see **3.2.5 Type of Bill Codes**). Physicians not employed by the home health agency must bill independently for their services.

3.1.5.2 Crossover Claims

Medicare pays for some physician-ordered services for Medicare eligible clients. Medicaid is only responsible for the deductible and coinsurance amounts.

See **Section 2.5, General Billing, Crossover Claims**, for more information on crossover claim submission.

3.1.5.3 Interim Payment

Interim payment is based on the lesser of the Medicaid cost caps established by DHW on a state fiscal year basis or billed amount.

- Skilled nurse visit
- Home health aide
- Physical therapy
- Occupational therapy

Final payments are the lower of reasonable costs as determined by the Medicare finalized cost report or the Medicaid cost caps.

Note: Mileage is included as part of the per-visit payment.

3.1.5.4 Evaluation Visit

Payment for the initial nursing evaluation visit depends upon the client's need for home health services. The provider should bill according to the following requirements:

- If the client needs further home health services, bill the evaluation visit as a skilled nursing visit.
- If the client does not require home health services, the visit must be charged to the agency administration cost center.

3.1.5.5 Healthy Connections Referral

If the client is enrolled in Healthy Connections, Idaho's Managed Care Program, a Healthy Connections referral is required from the client's primary care physician. That physician's referral number must be on the claim submitted by the Home Health Agency.

3.2 Home Health Service Policy

3.2.1 Overview

Home health program services include physician-ordered home health services delivered under a written plan of care. These include nursing services, home health aide services, physical therapy, and occupational therapy.

3.2.2 Limits

Home health services are limited to a total of 100 visits per client per calendar year.

3.2.3 Plan of Care

Federal and State Medicaid regulations require home health providers to have an established plan of care for each client and to have each client's plan reviewed by the attending physician every 60 days. A current plan of care must contain the physician's signature, dated within the required 60-day time frame. The home health agency must maintain a copy of the plan of care.

3.2.4 Medical Equipment and Supplies

3.2.4.1 Overview

Physician ordered medical supplies and rented medical equipment must meet the following criteria for Medicaid payment:

- Medically necessary
- Suitable for use in the home
- Reevaluated at least once every 60 days

3.2.4.2 Rental Costs

DHW may arrange purchase agreements with providers to purchase medical equipment when the rental charges total more than the purchase price of the equipment. All such purchases will be handled separately from the home health program as medical vendor transactions.

3.2.4.3 Influenza Vaccinations

All routine injections are included in the home health agency scheduled visits. The exception to this rule is the administration of the influenza vaccine. DHW will reimburse the agency "injection administration" costs if no other home health visit is billed on the same day as the vaccination. A description in the remarks section must indicate that "influenza vaccine" was administered.

3.2.5 Type of Bill Codes

Use one of the following type of bill codes that best describes your claim:

331 — Admit through Discharge

332 — Interim-First Claim

333 — Interim-Continuing Claim

334 — Interim-Last Claim

3.2.6 Revenue Codes

All home health services must be billed using unique, three-digit revenue codes. EDS will deny any claim with any other revenue codes entered.

Service	Rev. Code	Description
Home Health Supplies	270	Includes dietary products. All items must be included in the written plan of care.
Rental Durable Medical Equipment	291	All items must be included in the written plan of care.
Home Health Physical Therapy Visit	421	Must be included in the written plan of care.
Home Health Occupational Therapy Visit	431	Must be included in the written plan of care.
Skilled Nurse Visit	551	Requires the skills of a registered nurse (RN) or licensed practical nurse (LPN). Must be included in the written plan of care.
Aide Visit	571	Services that can be adequately performed by trained nurses aides. However, they may be performed by either licensed or non-licensed nursing personnel. Must be included in the written plan of care.
Drugs Requiring Special Coding	771	**Effective for dates of service July 1, 1999**, and thereafter, use revenue code 771, with the appropriate CPT procedure code. Also, use revenue code 771 and CPT code for the administration. Refer to Idaho Medicaid Information Release MA03-69 for more information on billing with J codes.

Information Releases are available on the Internet: **www2.state.id.us/dhw/medicaid/inf/mir.htm**.

3.2.7 Occurrence Codes and Dates

Enter one of the following codes in fields 32-36 on the UB92 claim form with the date of occurrence.

01 Auto Accident

02 Auto Accident/No Fault

03 Accident/Tort

04 Accident/Employment Related

05 Other Accident

06 Crime Victim

24 Date Insurance Denied

25 Date Benefits Terminated by Primary Carrier

42 Date of Discharge

X0 Plan of Care on file

3.2.8 Client Status Codes

Enter the appropriate status code in field 22 on the UB-92 claim form or the appropriate field on the 837 electronic form.

01 Discharge to Home

02 Transfer to Hospital

03 Transfer to Nursing Home

04 Transfer to State Hospital

05 Discharged to Another Type of Institution for Inpatient Care or Referred for Outpatient Services

06 Discharge/Transfer to Other (Indicate in field 84 the status or location of client and time they left the facility)

07 Left Against Medical Advice

08 Discharged/Transferred to Home Under Care of a Home IV Provider

20 Death

30 Not Discharged, Still A Client

40 Expired at Home

41 Expired in an Institution

42 Expired, Place Unknown

3.3 Claim Form Billing

3.3.1 Which Claim Form to Use

All claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red UB-92 claim forms available from local form suppliers.

All claims must be received within one year of the date of service.

See **Section 2** for more information on electronic billing.

3.3.2 Electronic Claims

For PES software billing questions, consult the *Idaho PES Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

3.3.2.1 Guidelines for Electronic Claims

Home Health Information

Idaho Medicaid requires the following Home Health Information when billing home health services on an electronic HIPAA 837 Institutional claim.

- Admit Date
- Discharge Date
- Nursing Facility Indicator
- From DOS
- Certification Indicator
- Type of Facility Indicator
- Diagnosis Date
- Occurrence span code of X0

Detail lines
Idaho Medicaid allows up to 999 detail lines for electronic HIPAA 837 Institutional claims.

Surgical procedure codes
Idaho Medicaid allows 25 surgical procedure codes on an electronic HIPAA 837 Institutional claim.

Four modifiers
On an electronic HIPAA 837 Institutional claim, where revenue codes require a corresponding HCPCS or CPT code, up to 4 modifiers are allowed. On a paper claim, only 2 modifiers are accepted.

Revenue codes, requiring procedure codes, which are broken into professional and technical components, require the appropriate modifier. For institutional claims, the TC modifier must be submitted.

Type of bill (TOB) codes
Idaho Medicaid rejects all electronic transactions with TOB codes ending in a value of 6. Electronic HIPAA 837 claims with valid type of bill codes not covered by Idaho Medicaid are rejected before processing.

Condition codes
Idaho Medicaid allows 24 condition codes on an electronic HIPAA 837 Institutional claim.

Value, occurrence, and occurrence span codes
Idaho Medicaid allows 24 value, 24 occurrence, and 24 occurrence span codes on the electronic HIPAA 837 Institutional claim. For Idaho Medicaid the occurrence span code must be X0.

Diagnosis codes
Idaho Medicaid allows 27 diagnosis codes on the electronic HIPAA 837 Institutional claim.

National Drug Code (NDC) information with HCPCS and CPT codes
A corresponding NDC is required to be indicated on the claim detail when drug related HCPCS or CPT codes are submitted.

Electronic crossovers
Idaho allows providers to submit electronic crossover claims for Institutional services.

3.3.3 Guidelines for Paper Claim Forms

3.3.3.1 How to Complete the Paper Claim Form

The following will speed claim processing:

See **Section 3.3.3.3**, for instructions on completing specific fields.

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- You can bill with a date span (From and To Dates of Service) when services were provided on consecutive days.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.3.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.3.3.3 Completing Specific Fields on the Paper Claim Form

Refer to 3.3.3.4, Sample Claim Form, to see a sample UB-92 claim with all fields numbered.

The following numbered items correspond to the UB-92 claim form. Consult the Use column to determine if information in any particular field is Required, Desired, or Optional. When the Use column is empty, refer to the Description column for additional information. Claim processing will be interrupted when required information is not entered into any required field.

Field	Field Name	Use	Description
1	Provider Name and Address and Phone Number	Required	Enter the provider name, address and phone number. The first line on the claim form must be the same as the first line of the RA. If there has been a change of name, address, or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
4	Type of Bill	Required	Enter the three-digit code from Section 3.2.5 311 — Admit through Discharge 312 — Interim, First Claim
6	Statement Covers Period	Required	Enter the beginning and ending service dates of the period included on the bill. Medicaid does not pay accommodation charges, or any fraction thereof, for last day of room occupancy when a client is discharged under normal circumstances. However, even though there is no reimbursement for the discharge day, that date should always be entered on the claim form. This ensures that the provider receives reimbursement for the last full day of accommodation. If a client requires extended care and the provider decides to send an interim claim, enter client status code 30 in field 22. This code tells the computer that the client is still a client and to reimburse the provider for the last day on the claim. *NOTE*: If client status 30 is **not** used, the accommodation rate formula will not balance and the system will suspend the claim.
7	Covered Days	Required	Enter the dates for days covered.
12	Patient's Name	Required	Enter the client's name exactly as it appears on the MAID card. Be sure to enter the last name first, followed by the first name and middle initial. Client name must be here or in field 58 .
17	Admission Date	Required	Enter the month, day, and year the client entered the facility. (This date will be the same on all claims submitted and will not necessarily be the same as the date found in field 22.)
18	Admission Hour	Required	Enter the two-digit hour the client was admitted for care in military time. Example: enter 01 or 02 instead of 1 or 2.

Field	Field Name	Use	Description
19	Admit Type	Required	Enter a priority admission code from the UB-92 Manual. Only the codes 1, 2, 3, or 4 are acceptable.
20	Admit Source	Required	Enter the two-digit source of admission codes, 1 through 8, from the UB-92 Manual. Medicaid does not accept 9.
21	Discharge Hour	Required	Enter the two-digit hour the client was discharged from care in military time. Example: enter 01 or 02 instead of 1 or 2.
22	Status Codes	Required	Enter the appropriate code from Section 3.2.8.
32-36	Occurrence Codes and Dates	Required	Use one of the codes listed in Section 3.2.7, Occurrence Codes and Dates, and enter the date of occurrence. X0 is required with Idaho Medicaid.
39-41	Value Codes and Amounts	Required	
42	Revenue Codes	Required	All revenue codes are accepted by Idaho Medicaid; however, not all codes are payable. Use revenue code 001 for a total line and enter the claim's total in field 47. See Section 3.2.6.
44	HCPCS/Rates	Required	All accommodation codes require rates.
46	Units of Service	Required	Enter the total number of covered accommodation days, ancillary units of service or visits, where appropriate. Units of service for accommodations must correlate accurately to the service rendered. Example: Accommodation Code = Number of days the service was rendered.
47	Total Charges	Required	Bill total covered charges only. Rate Formula: Total Charges = Rate x Units of Service
50	Payer Identification	Required	If Medicaid is the payer, enter "Idaho Medicaid". If there are other payers in addition to Medicaid, enter the name of the group or plan in fields 50A or 50A and 50B. Enter "Idaho Medicaid" in fields 50B or 50C.
51	Provider Number	Required	Enter the nine-digit Idaho Medicaid provider number in this space.
54	Prior Payments — Payers and Client	Required if applicable	Enter any amount paid by other liable parties or health insurance payments including Medicare. Attach documentation from an insurance company showing payment or denial to the claim. Do not include contractual adjustments.
55	Estimated Amount Due	Required if applicable	Estimated Amount Due = Total Charges (field 47) minus Prior Payments (field 54).
58	Insured's Name		Client's name must appear here or in field 12.
60	Cert-SSN-HIC-ID Number	Required	Enter the client's seven-digit MID number exactly as it appears on the MAID card in this field. If your computer system demands an 11-digit MID, zero fill the eighth through the eleventh digits. Example: 02345670000. All third party resources must be billed before a claim is submitted to Medicaid. If there are other payers in addition to Medicaid, enter the name of the group or plan in fields 60A or 60A and 60B. Enter Idaho Medicaid in fields 60B or 60C as secondary or tertiary. For Medicare crossover claims, be sure the Medicaid MID number is documented in addition to the Medicare SS number.
67	Principal Diagnosis Code	Required	Enter the ICD-9-CM code for the principal diagnosis.

Field	Field Name	Use	Description
76	Admitting Diagnosis	Required	Qualis Health has designated specific V codes that are not appropriate as admitting diagnoses. Consult the Qualis Health Manual.
82	Attending Physician ID	Required	Enter the Idaho Medicaid Provider number or UPIN for the physician referring the client to the provider.
83	Other Physician ID	Required if applicable	Required for Healthy Connections clients referred to the provider by the primary care provider. Enter the primary care provider's Healthy Connections referral number. Desired for all other claims.
85	Provider Representative Signature	Required	Signature of the provider's authorized agent or signature on record. The claim will be denied if it is not signed.
86	Date Bill Submitted	Required	Enter the date the claim is submitted to Idaho Medicaid.

3.3.3.4 Sample Paper Claim Form